Alaska Mental Health Trust Authority Mini-Grants
Application Instructions

Who Qualifies:
Anyone diagnosed with Alzheimer's disease or a related dementia including Parkinson's Dementia, Multi-Infarct Dementia (stroke-related), Pick's Disease, Lewy Body Dementia, Huntington's Disease or Cruetzfeldt-Jakob Disease.

Funding Criteria:
Mini-grants funds may be requested for the following:

- Essential items which will directly improve the individual's quality of life and increase independent functioning.
- Medical, dental, vision, hearing, supplies, therapeutic devices, adaptive equipment, and accessibility improvements.
- No other funding source is available for the item or service requested. No existing bills.

Review Application Checklist:

1. The beneficiary or the beneficiary's family member, care coordinator, legal guardian, power of attorney or another person may apply.
2. **If applicable, the signature of legal guardian or power of attorney is needed.**
3. All information must be completed on the form; incomplete applications will be returned.
4. Attach a written estimate from vendor (store, provider or supplier) to be used. If applicable add shipping, handling and/or installation charges.
5. Verify that person requesting grant has one of the qualified diagnoses listed above. If available attach supporting documentation of diagnosis.
6. Verify the physical address of person on application form.
7. Please note the maximum Mini-Grant request is $2,500; however an applicant may submit more than one application per year, as long as the combined applications do not exceed $2,500.
8. Mail or Fax application to: **Alzheimer's Disease Resource Agency of Alaska**
   1750 Abbott Road, Anchorage, AK 99507
   Fax (907) 561-3315

How the process works:
Submit a completed mini-grant application with an estimate from the vendor to be used for the item or service requested. Application will not be processed until all information is completed. Completed applications are considered for funding based on level of need and date order. Once a grant is awarded we will notify the applicant and we will send a Purchase Order (PO) directly to the vendor**. Important Note**: **Do not pay for item or service out of pocket. Payment will be made directly from the Alzheimer's Resource of Alaska to the vendor for the items or services purchased for the Beneficiary.** A check for payment is sent to vendor after an invoice for completed item or service is received by the Alzheimer's Resource of Alaska. Grant will not pay for an existing bill. **For additional information visit our website www.alzalaska.org or call us at (907) 561-3313.**

These Mini- grants are generously funded by the Alaska Mental Health Trust Authority.

Alaska Mental Health Trust Authority Mini-Grants Application

Please complete all information. Attach a copy of the written estimate for the items or services needed.

Person filling out this application

Name_____
Address _____
City _____**Zip** _____
Day Phone _____
Evening Phone _____
E-mail _____
Fax _____
Relationship to Beneficiary _____

PHYSICAL ADDRESS OF PERSON TO RECEIVE GRANT
(For delivery of items or services)

Address_____
_____
City _____ **Zip** _____
Name of Facility/ALH if applicable_____
_____

Person who will receive the services or items from this grant

Name _____
Circle Dementia Diagnosis: Alzheimer's Parkinson's Stroke-related Pick's Disease Lewy Body Huntington's Cruetzfeldt-Jakob Disease
Social Security Number _____
Date of Birth _____**Age**_____
Gender *(Circle one)* Male Female

Ethnic Background *(Circle one)*
Native Alaskan/Native American Hispanic
Caucasian (Non-Hispanic) Black
Asian/Pacific Islander Other _____

Beneficiary Coverage *(Circle yes or no for all options)*
Medicaid Y N
Medicare Y N
Choice Medicaid Waiver Y N
Other Insurance_____

Amount of Mini-Grant Request: _____ (Maximum $2,500)

Specific Item(s) or services to be purchased with this Mini-Grant_____
_____

Explain how this Mini-Grant will allow Beneficiary to receive an essential item, how the item will increase independent functioning, and how it will improve the Beneficiary's quality of life:

_____
_____
_____
_____

Store or supplier (Vendor) from which the item(s) or service(s) will be purchased:

Name of Store or Supplier _____
Address _____**City**_____**State**_____**Zip**_____
Phone _____**Contact Person** _____

This Mini-Grant Application must be signed in order to be processed
Please Review Application Checklist on other side

I certify that the information submitted in this form is true and accurate to the best of my knowledge. It is my understanding that the items or services for which I've requested this Mini-Grant are not covered by any other funding source.

Signature of Person filling out application _____ Date_____

Signature of Person to receive grant or legal guardian or Power of Attorney _____Date_____